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‘Not living life in too much of an excess’: lay men understanding health and well-being

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ABSTRACT While research on lay perspectives of health now has a well-established history, specific empirical data on male lay perspectives of health and well-being are largely absent. Drawing on focus group data and in-depth interviews with 20 lay men (including sub-samples of gay men and disabled men), and seven health professionals, this article explores how the men conceptualized ‘health’ and the gendered nature of such conceptualizations. Specific emphasis is given to considering notions of ‘control’ and ‘release’, and the associated issues of ‘risk’ and ‘responsibility’, in the participants’ health narratives. A conceptual model for understanding ‘masculinity’ and ‘health’ is presented.

KEYWORDS *lay perspectives; masculinity; men’s health; responsibility; risk*

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Introduction

While the bulk of research on ‘lay perspectives’ has tended to focus more on ‘illness’ than on ‘health’ (Hughner and Kleine, 2004), it nevertheless remains the case that research on lay perceptions of health and well-being has a well-established history, with work stretching back over 30 years (e.g. Herzlich, 1973; Pill and Stott, 1982; Williams, 1983; Cornwell, 1984; Crawford, 1984; Calnan, 1987; Blaxter, 1990). Such work has consistently shown the importance that lay people attach to understanding health as something integrated into daily life rather than *only* being about the

optimum functioning of physiological bodily systems. In this respect, lay perceptions have been significant in influencing a cultural shift away from a wholly bio-medical approach and towards a more integrated and holistic understanding of health and well-being.

In recent years, a more precise understanding of how lay perceptions can function to help address contemporary health problems in the areas of public health and health inequalities has also been outlined (Popay and Williams, 1996; Popay et al., 1998, 2003). Yet, despite the clear importance of lay understandings, and an ever-increasing interest in health promotion work with men, with a few notable exceptions (Mullen, 1993; Saltonstall, 1993; Watson, 2000; Robertson, 2003; O'Brien et al., 2005), very little research has specifically considered lay men's perceptions about health and well-being. This stands in stark contrast to the burgeoning research on lay men's accounts of ill-health and chronic disease (e.g. Gordon, 1995; Cameron and Bernardes, 1998; White, 1999; Pateman and Johnson, 2000; White and Johnson, 2000; Chapple and Ziebland, 2002; Riessman, 2003; Gannon et al., 2004).

This article draws on some of the findings from a recently completed three-year study, exploring lay men's and community health professionals' attitudes towards 'masculinity' and 'preventative health care', conducted in the north-west of England. The focus here is on the conceptualization of 'health and well-being' among the respondents, and the article thereby adds to the small amount of empirical data currently available concerning male lay perspectives on health and well-being. More specifically, I explore the contested nature of male gendered discourses on health, including accounts of risk and responsibility, and propose a conceptual framework for considering the relationship between men, masculinity and health.

Methods and design

The overall design within this project was broadly interpretivist in nature and followed a process of abductive reasoning. Within abductive reasoning, distinctions between theory testing and theory generation are diminished; instead, a process that facilitates movement between everyday concepts and meanings, lay accounts and theoretical explanations is developed. Theory, data generation and data analysis are dialectically and dynamically related rather than being built in linear fashion one from the other in order to test or generate theory (Blaikie, 1993; Mason, 1996: 142).

After receiving Local Ethics Committee approval and consent, two focus groups and two sets of in-depth interviews were carried out with 20 lay men aged 27–43 years. These men included seven gay men, accessed with help from the local health promotion unit; six disabled men, accessed through a contact in the local authority leisure department; and seven non-gay, non-disabled men accessed through two large GP practices. The in-depth interviews were semi-structured with a few direct open questions being asked of all the men (these are indicated in the Findings section) but generally

being a discussion led by the men on the issues that arose during the focus group sessions.¹ In addition, two focus groups and seven in-depth interviews were carried out with a range of community health professionals also accessed through the two GP practices. This article focuses predominantly on the data from the men themselves although reference is made to the data collected from the health professionals. These groups of men were chosen to represent a range of what Connell (1995) terms 'configurations of (masculine) gendered practices', including hegemonic, subordinated and marginalized masculinities. In this sense, the sample is a theoretically derived, purposive sample (Silverman, 2000: 105).

Preliminary data analysis was completed following each group of three to four interviews through a process of iterative reading and listening and identification of emerging themes. Further analysis was completed after all the participants had been interviewed. How the men conceptualized health and well-being formed a major theme, and all texts pertaining to this were highlighted. Detailed sub-coding of these texts, and how these sub-codes related to each other and to previous theoretical work on lay understanding about health, was then undertaken in order to facilitate the development of a conceptual model for understanding men, masculinity and health. This constituted an adapted form of the 'constant comparative method' (Glaser and Strauss, 1967) of analysis with the adaptation coming through the inclusion of previous theoretical work into the continual motion between larger and smaller data sets. The appropriateness of utilizing the constant comparative method of analysis in this way has been noted by Mason (1996: 142).

In what follows, data extracts are rendered anonymous through the use of pseudonyms but are identifiable as coming from health professionals (HP), gay men (GM), disabled men (DM) or contingently able-bodied and straight men (CABS).²

Findings

At first glance, the data here reflected the general themes found in previous research on lay perspectives (for a review of these themes see Hughner and Kleine, 2004), and the more specific themes relating to male lay perspectives (see Mullen, 1993; Saltonstall, 1993; Watson 2000). Health as the absence of illness, as the ability to function, as fitness and as 'looking good' or 'feeling good', and combinations of these, were all recurrent narratives throughout the interviews. However, a more nuanced analysis, explicated below and facilitated by the process of abductive reasoning outlined earlier, revealed more specifically the complex, and often contradictory, nature of these male lay accounts.

A direct question asking the men how they understood health was asked in all the initial interviews and seemed to cause difficulties in knowing how to respond for some:

I: So if you were to think about what health meant to you, what would you say it was?

Quinn: What do you mean?

I: If you were to try and define health.

Quinn: Well, apart from me illness, I don't have any health problems. So I never think about it 'cause I'm fine apart from the illness. (Quinn, DM)

This could be because, as Bourdieu (1990) argues, the practices of everyday life, including health practices, are not wholly consciously organized but rather are accomplished unthinkingly and routinely through what he terms 'practical consciousness'. This 'practical consciousness' develops from an individual's 'habitus', that is, an acquired set of generative dispositions formed in the context of people's social locations. Yet, part of what forms an individual's 'habitus' are the public meta-narratives regarding what constitutes appropriate, gendered behaviour(s) or expressions of belief. In this regard, the idea, or expression, of not considering health may itself be linked in to notions of masculinity and gender. Blaxter (1990: 19) noted that three times as many men as women considered that health was a 'normal' state and, from responses in this research, this does seem to be related in part to a wider public discourse that men are not, or should not be, interested in their health:

It's [health] important to women, innit? But blokes don't really bother about it. (Quinn, DM)

I think it's, it's not even an attitude, it's a non-attitude towards health. They [men] don't see it [health] as a problem. (Martin, CABS)

The rhetorical distancing (the use of the third person rather than the first person – 'But blokes ...' and 'they don't see it ...'), found in these (and other) interview extracts highlights a tension experienced by the men in aligning themselves personally with such lack of concern, suggesting as it does that this was how *men were* but not necessarily how *they are*. This distancing can be seen as a way of resolving, or more accurately managing, two conflicting discourses: first, that 'real' men do not care about health and second, that the pursuit of health is a moral requirement for good citizenship: what I term the 'don't care/should care' dichotomy.

It is clear that health did carry such moral connotations for the men interviewed, present in both their public and private accounts, and being presented in simplest form as what one should or should not do:

I: What does health mean to you?

Neil: Er, it does mean a lot, but I don't tend to it as much as what I should do. (Neil, GM)

The writing of Armstrong (1983, 1995), Crawford (1984, 1999, 2000) and Petersen and Lupton (1996) among others, explores how this moralizing rhetoric of health promotion, that is then internalized by individuals, is utilized as a means of control, a way of managing and maintaining 'healthy

producers', within late modernity. Crawford extends this argument through recognition that capitalism in late modernity also requires the same individuals to be 'healthy consumers', an ideal that has become synonymous with 'fun, immediate gratification, and a propensity to exceed limits' (Crawford, 2000: 222). In this sense, 'a little bit of what you fancy does you good', release from control, becomes constructed as healthy *in itself*. Strict adherence to bodily disciplinary regimes and lifestyles has to be offset by release, pleasure, often actively constructed in opposition to a 'healthy lifestyle', in order to achieve a 'healthy balance'. This interplay of control and release, played out in the health arena among other areas, is seen as a system requirement in late capitalism and creates a challenging task for health promotion in managing this ambivalent relationship.

Martin provides an example of how such tension is managed through an understanding of health as balance, or as life needing all things in moderation, narratives found throughout his interviews:

I do keep fit. Um, don't drink too much, don't smoke too much, well I probably do at times [laughs]. Watching what I eat to a certain extent, eating fruit and vegetables. Um, so keeping fit, eating healthily and not living life in too much of an excess. (Martin, CABS)

The rhetoric of balance and moderation was frequently invoked in this way as a means of trying to bring together the need for control and the desire for release in terms of health practices and suggests that Crawford's model has resonance with the empirical data in this study. Some men even went as far as recognizing this tension as an inherent part of modern life and driven by consumerism:

I eat healthy food generally and I cheat now and again. Alcohol's bad for you, but we all drink, mostly everyone I know likes a drink, 'cause it's good for you, it actually cheers you up . . . We've got like this throwaway society and I think people's perceptions are changing, everybody wants everything yesterday. And long may it continue as well. People want to gain as much as possible materialistically, physically and emotionally. And that's it, get fit one day, get drunk the next, buy the best house in the country the day after, you know, and that's a full life. (Dan, CABS)

This moralizing of health, which leads to consideration of issues of control and release, is mediated through ideas about risk. The 'healthy citizen' is one who recognizes, and limits (and transgresses?) risks both to themselves and others; this is part of a wider duty to achieve and maintain good health (Petersen and Lupton, 1996: ch. 3).

Yet notions of 'citizenship', and therefore what constitutes risk, are themselves gendered. In health professional literature on masculinity and health, men are represented at various times as both 'risk-takers' focused on transgressive acts (in terms of fast driving, excessive drinking, smoking, violence) and those 'at risk' (in terms of reduced longevity), and these two risk rhetorics are often combined to form a circle of explanation regarding

men's health (for recent examples see Banks, 2001; Peate, 2004). That is to say, the 'risk taking' is, at least in part, seen as responsible for the mortality/morbidity that situates them as 'at risk'. There were strong narratives, particularly from the female health professionals who had male children, that boys and young men were vulnerable, misjudged, but also that they were careless with regard to the risks they took with their health. This carelessness was linked in turn to peer group pressure and the need to perform a 'macho' style of male behaviour:

It's just an assumption of health really. You know, you can drink, you can eat you can smoke and do all these things. It's all an adolescent sort of attitude really, a cavalier attitude to their health really, you know, sort of 'macho', one of the boys. (Collette, HP)

Others suggest that to be a 'good' (normative) male citizen is to invite in, rather than avoid, risk, and health then becomes subsumed under the need to form (or express) one's masculine identity in this way (Petersen and Lupton, 1996: 80ff.). In order to explicate these emerging issues around risk further, a question asking if the men could describe a time when they had put their health at risk was asked at the second interview. The replies from some of the men seem to crystallize a more complex relationship between men and 'health risks':

Nothing instantly springs to mind, obviously driving too fast, smoking too many fags, drinking too much beer, but it's not what I see as putting myself at risk, it's not like playing chicken or anything like that with an on-coming car. So, everything I've done is measured and controlled within what I think are safety sort of parameters really. So I don't generally take too big a risk. (Martin, CABS)

In this sense, for most of the men, 'risk' is invited in, but not in an un-measured way. This mirrors the notion of 'edgework' proposed by Collinson (1996) who described how young male offenders mobilized notions of 'risky' activities they had been involved in, 'living on the edge', as a means of performing dominant masculinity. However, the data here do not directly replicate the notion of 'edgework' as understood by Collinson. He relates 'edgework' to a need to transcend the banality of everyday existence for the young men in his research. The understanding of 'edgework' here suggests it can also represent part of an 'ordinary', regular part of being male, or demonstrating hegemonic masculinity *in* daily life, not solely as a transcendence of it. It seems this 'edge' is representative of a path between control and release, but also between 'don't care/should care', that must be walked to reach or maintain (hegemonic) male identity.

Discussions about masculinity and risk in the health literature often take place in a void, abstracted from other aspects of daily existence and linked only to aggregated statistical data. In reality, for the men in this research, 'risky' lifestyle behaviour was very much socially integrated and often engaged in to offset other practices also perceived as 'risky' in health terms.

Smoking seemed to provide a particular example of this for three of the men and was perhaps most clearly expressed in Hugh's interviews:

Nearly every chef I know smokes cause it's such a stressful job. It's not meant to be healthy, is it? But to me it's my form of release from the pressure of my job. It's like a drink. I always have a pint after work to try and calm myself down a bit before I actually get home and then I'll probably have another can or two when I get in. They're like releases of stress for me, part of cooling down, chilling out. . . . I know I should give up smoking and that for the kiddies but it's just that I don't know how I'd cope without it. (Hugh, CABS)

Hugh takes his work very seriously, and narratives about the importance of not phoning in sick, never having had a day off work and the restaurant trading off his name, are prevalent in the interviews. Yet he attaches a high stress rate to the job and sees smoking, and having a few drinks after work, as a means of reducing the stress and thereby the risk to his health posed by stress, while recognizing that these activities in themselves pose a risk to his health. Thus, in line with Graham's (1987) research into women's smoking, the empirical data here also suggest that specific 'unhealthy' practices (for Hugh, smoking and high alcohol intake) are engaged in as a means of coping with real, material pressures of everyday life that are also experienced as presenting 'risks' to health and well-being.

For Peter, the sudden experience of severe physical impairment at the age of 20 necessitated a reconsideration of his (male) identity. This (re)construction required engaging in 'risky' behaviour when attempting to re-establish his acceptance, and specifically acceptance as a man, among peers:

I think I went through a stage when I first broke me back of proving my manhood, I was a right git towards women, I used to have one after the other. I was trying to prove me manhood again, that I still had it. . . . I got in with a crowd who took drugs, basically, and I went with the crowd. Because of my medical condition I really could have caused myself some real damage. I was trying to fit in. I suppose that was about getting respect because I'm associated with this person who is, or was, one of the biggest dealers in this area. (Peter, DM)

A simplistic model of explanation in relation to risk taking and male identity, that of inviting risk in and the concomitant impact on health, fails to do justice to the complexity of the issue of control, release and identity formation for the men in this research. The 'risks' taken by Peter, sexual health risks and drug taking, would perhaps have quite a different meaning for women, possibly resulting in social isolation or non-acceptance, rather than as a means of being accepted. *'Risk' in this sense is not about probability, the chance of an event happening, but is integrated, woven, into the gendered fabric of society's expectations.*

The place of responsibility

That men's presentation as being 'unconcerned' about health may be related more to a dominant discourse about how men ought to behave,

rather than the private reality of men's lives, has been highlighted earlier in the article. Narratives of 'responsibility' as well as 'risk' narratives formed a significant part of the interview data and suggest a more complex and contradictory relationship between men and their health practices than much 'men's health' literature currently recognizes.

Previous work (Backett and Davison, 1995) has examined how lifecourse events impact on and influence lifestyle in relation to health practices. The taking on of individual responsibilities, particularly settling with a long-term partner and becoming a father, altered not only the way that men thought about health, but their actual health-related practices. Owen considers the impact of entering a co-habiting relationship and fatherhood:

I do everything that normal people do. We drink, go out at weekends, we eat take-aways but eat at home as well, we do everything a mixture. I can't think of any time that we've really done it to excess, especially not now I've got me daughter . . . It did change when [daughter] was born. You try and get as much sleep as you can, eat when you can, you've got to look after yourself 'cause you've got to be alert, ready, you know, just in case. (Owen, CABS)

A need to exert self-control predominates over the desire for release at particular ages and stages of the lifecourse for the men, resulting in changes in health-related practices, and this finding is supported by previous work on lay men and health (Mullen, 1993; Watson, 2000). These changes seem to be due to two separate (but probably interrelated) moral elements that require emotional investment. First, it seems to be deontologically driven; that is, it is rule based. To be a good, dutiful, partner and father, as Owen suggests above, requires the limiting of excess in order to be alert and available to meet the needs of a dependant. Second, it seems to be teleologically driven; that is, driven by recourse to outcomes, in this case the desire to be there for the child as it grows older and therefore to live long enough to enjoy this. As Larry explains when asked if he feels it important to live a long life:

It wasn't when I didn't have [his son]. But it is now, I want to enjoy him, I want him to know that he can enjoy me. Let him know that I'll be here for him at every stage of the way, basically. It's very important to me to know that he can see me anytime, talk to me about anything. I'll work my rocks off for him, you know what I mean? The business is his, the house is his, and everything I have is his, full stop. (Larry, CABS)

This is more than just rhetoric for Larry, who is diabetic and prior to getting married and becoming a father refused to inject insulin, due to a needle phobia, for over 18 months. He now feels it sufficiently important to work through this phobia, and consider ways to maximize his health and longevity for the sake of his son and his own desire to see him grow up.

The need to demonstrate hegemonic masculinity through 'risk-taking', 'edgework', takes on reduced significance as men move into stable partnerships, including gay partnerships, and fatherhood. Yet this does not

necessarily represent a move away from hegemonic ideals. As Owen and Larry's narratives suggest, other hegemonic ideals of taking control, and of being the material provider, are drawn on to support this change in reducing the propensity towards risk and excess. In this sense, what constitutes a hegemonic masculine ideal may alter through the lifecourse, and the expectation to demonstrate 'edgework', a hegemonic ideal for younger or single men, shifts towards an ideal of 'controlling excess' when the responsibility of a stable relationship, and particularly fatherhood, are entered into.

In direct discussions on responsibility, all the men indicated that, while the health service had a duty to provide information regarding health issues, it was up to the individual to choose to act, or not, on this information. There were strong narratives about the need to take individual responsibility for health in terms of lifestyle choices:

If you wanna change something in your life, there's only *you* can do it. If you wanna stop smoking, *you've* gotta stop smoking. If you wanna stop eating bloody fatty foods, its *you* who's got to stop eating fatty foods, you know. (Ron, DM)

This, and earlier extracts concerning healthy diets and exercise, contrast markedly with views expressed in the health professional literature, and echoed in the data from the health professionals, that suggests, either overtly or covertly, that men fail to accept that they have responsibility for their health. Yet, when giving direct examples of when and how they took responsibility for their health, all the men provided explicit reasons for doing so; they could not be seen to be 'doing' health for its own sake. Not to provide an explanation would seem to run the risk of not being a (real) man, and explanations were used to legitimate an interest in health, thus allowing resolution of the 'don't care/should care' dichotomy (see also Robertson, 2003).

This situation was slightly different for the gay men. Both the gay men themselves and the health professionals believed that gay men care more about their health than straight men. It seems that the rise of HIV/AIDS, and the association of gay men with (stereotypically) feminine characteristics (an association made by most of the gay men interviewed), combined to legitimate, and perhaps even make a moral requirement, caring about health issues for gay men. This allowed them to dispense with a 'don't care' approach and was apparent in all the interviews with gay men and is summed up well by Gary: 'I think gay men are more aware of their health than straight men. I'm not saying that about all gay men and all straight men, but on the whole I think that gay men are more health conscious' (Gary, GM). However, this may also mean that gay men are under a greater imperative to be seen to care for their health and well-being and are therefore judged more harshly, including by their peers, should this appear not to be the case.

The moral role of individual responsibility for health also raises particular issues for those with chronic illness or physical impairment who, as Williams (1993) and Galvin (2002) suggest, may feel under more obligation to present

themselves as virtuous. For such men interviewed as part of this study, their impairment or underlying pathology could represent a further explanation for being concerned about their health, a way of resolving the 'don't care/should care' dichotomy. Peter provides an example:

I think, since I've been in the chair, I've watched what I've eaten because I can't lose it, cause I've got no sensation. I'm worried honestly about getting a belly and not being able to get rid of it 'cause I can't work it. (Peter, DM)

In this sense, particular physical circumstances – for Peter being a wheelchair user – can almost obliterate the 'don't care/should care' dichotomy, leaving a 'must care' model, again creating a greater imperative to make 'correct' lifestyle choices.

Yet, as Gerschick and Miller (1995) suggest, acquiring a physical impairment risks being emasculating and can move these men towards the boundary between hegemonic masculine identity and a feminized, and thereby marginalized, identity. Losing the 'edge' represented by this dichotomy risks the loss of (hegemonic) masculine identity, and some of these men specifically (re)inserted aspects of 'don't care' into their narratives, symbolically using the very 'vulnerability' that is meant to make them take (?more) care, as a way of presenting who they are. As Quinn explains during a discussion on whether he wants to live a long life:

I just don't think about it, never think about it. Like I'll go down the kerb right, most people in a wheelchair will turn round and go down backwards. I don't, I just go straight down the kerb, you know, throw meself off it. [...] I mean, if I fell out of the chair and hurt meself then, the way I think is just like able-bodied people, they just don't think about it and neither do I. If I get hurt, I get hurt. I've always been like that, I've always just got on with it. (Quinn, DM)

Quinn is not trying to deny his impairment here, or the effects of it, but he is showing that his attitude or approach to life is the same as that of an 'able-bodied' person. Yet this person is not asexual. In drawing on the rhetoric of risk, danger and lack of concern, as well as suggesting his skill and control in the handling of his wheelchair, Quinn is expressly demonstrating his normal *male* attitude and approach to life. His 'not thinking about it' also reaffirms Bourdieu's (1990) point that such actions (including the way that they are gendered) are often unconsciously entered into, representing part of a 'practical logic' demonstrated in everyday life.

However, it is not just caring too much about health that puts hegemonic identity at risk. Not to take enough care with one's health, particularly through indulging in excess, also moves one away from hegemonic ideals. It suggests irresponsibility and lack of control, which then becomes representative of transgressive (male) behaviour, as the following conversation suggests:

Frank: If you enjoy a burger, eat it. If there was a salad I didn't enjoy, and a burger that I would enjoy that was gonna do me more harm, I'm sorry but I'd eat the burger.

I: So part of living a full life is

Frank: Enjoy your life. I think you have to be a bit sensible, you can't be totally brash, you have to be sensible and responsible to a point. There's a point and once you get past that point you're being silly again. Some people are too careful, that's not me.

I: So it's a balance?

Frank: Yeah, *you've got to get it right.* (Frank, DM, emphasis added)

This narrative provides a strong sense of the work required in balancing not only the 'don't care/should care' dichotomy but also balancing the tension between control and release in order to achieve or maintain 'healthy' hegemonic, male citizenship.

Concluding comments

In seeking here to explore lay men's accounts of health and well-being, the aim is not to ignore or diminish the impact of structural determinants in men's health outcomes but rather to consider how the relationship between men, masculinity and health, that both reflects and reproduces such social structures, is conceived and practised. It is in this way that, as others have also suggested, lay narratives can contribute to bridging the gap between issues of structure and agency (Popay et al., 1998).

Through the empirical data presented, attention has been drawn to the importance for men of showing, at least publicly, indifference to health and how this conflicts with the drive in late modernity for 'good' citizens to manage their health and minimize risks to it. While the concepts of 'control' and 'release' are well established within lay accounts of health and well-being, what emerges here is how a 'healthy balance' between control and release is also negotiated with regard to one's (male) gendered identity. In this way, as Saltonstall (1993) suggests, 'doing' (and I would suggest giving the appearance of not doing) health therefore becomes a way of 'doing' gender. In managing the 'don't care/should care' dichotomy, narratives of 'control' and 'release' are drawn on in different ways and at different times to construct (or resist) hegemonic forms of masculinity.

A model emerges (Figure 1) that signifies a relationship between the 'don't care/should care' dichotomy and narratives of 'control' and 'release' and how they are mobilized in regard to the construction of hegemonic masculinity. Just as masculinities are not static but rather represent configurations of gender practice that men move within and between, so the four health discourses that form the axes in the model are mobilized in different ways at different times in order to achieve (or reject) hegemonic ideals. The holding together, or management, of these four aspects requires effort, although, as suggested previously, it is often achieved unconsciously as part of everyday life. Lack of ability, or desire, to hold these together can situate men in the four outer zones, that come to represent a symbolic 'no man's land'. While this may be a deliberate positioning for some men,

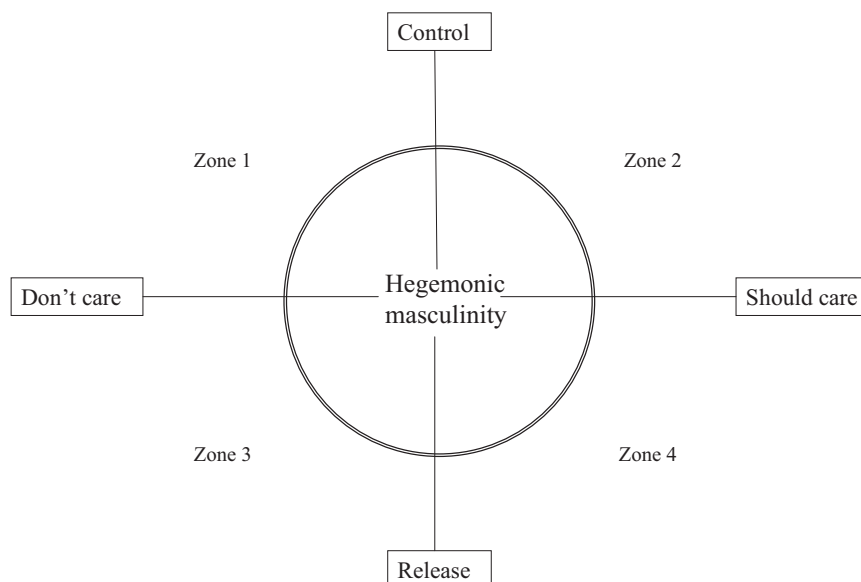


Figure 1 Model of the relationship between health and hegemonic masculinity.

providing a place or space to challenge hegemonic ideals, others are involved in an almost constant (though not necessarily conscious) self-monitoring process, ensuring that they do not stray outside the ‘inner circle’ (or target) of hegemonic masculine identity.

This model allows a challenge to assumptions and stereotypes that simplistically construct men as innate risk-takers (see also Lyons and Willott, 1999) and opens up a conceptual space for considering how, when, where and why men take responsibility for their health and well-being. While this article has begun the process of exploring this space, a considerable amount of empirical work remains to be done to understand more fully the relationship between men, masculinity and health practices.

Notes

1. Such a combination of direct questions (though conversational in style) and participant-led discussion is appropriate within an abductive reasoning framework as it helps facilitate the dialectic movement between theory, data collection and data analysis.
2. It is recognized that the process of ‘labelling’ people is highly problematic, fraught with ambiguity and the potential for offence. However, when looking at sets of relations it allows for the exploration of similarity (as well as difference) when people share some characteristics, in this case being male, while differing in others. The term ‘contingently able-bodied and straight’ (CABS) is used in this research to recognize those men that did not identify as being gay or disabled. It is used in preference to terms such as non-gay, non-disabled as it is more fluid, recognizing that identities can change over time and that those

interviewed may have experienced, or may go on to experience, same-sex relationships or periods of physical impairment.

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